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MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations

FROM: Allen Dobson, MD

Mike Moseley

SUBJECT: **Enhanced Services Implementation Update #17 – Various Clarifications**

This update contains clarifications on a variety of topics.

Community Support for Co-Occurring Diagnosis

For a Community Support (CS) provider serving consumers with a co-occurring diagnosis of MH and SA, the primary diagnosis of the consumer determines the disability for which the CSS professional must have QP status.

- If the consumer has a primary SA diagnosis and a secondary MH diagnosis, the CSS professional must be a QP in SA. A qualified or licensed MH professional shall be consulted to determine the treatment or other MH Service needs of the consumer. If there is a need for active MH treatment, the treatment must be appropriately addressed by a qualified or licensed MH professional.
- If the consumer has a primary MH diagnosis and a secondary SA diagnosis, the CSS professional must be a QP in MH. A qualified or licensed SA professional shall be consulted to determine the treatment or other SA service needs of the consumer. If there is a need for active SA treatment, the treatment must be appropriately addressed by a qualified or licensed SA professional.
- In either circumstance, the provider may either provide such services directly through their own staff, or may arrange for the provision of such services through another community provider.

Enhanced Services Implementation Update #7 incorrectly stated that "...the Divisions of MH/DD/SAS and Medical Assistance have extended the original six-month post-implementation period regarding provisionally licensed outpatient therapists and **non-licensed interns** [emphasis added]... The extension is until June 30, 2007."

The Update should have only indicated that the extension applied to provisionally licensed professionals. Non-licensed interns and other non-licensed individuals who may have previously provided outpatient therapy can no longer bill Medicaid for those services as of 9/20/06.

Non-licensed interns and other non-licensed individuals may meet the criteria for Qualified Professionals and, as such, may be able to provide some of the other services as described in the approved service definitions. The Administrative Rule that defines Qualified Professionals can be found at 10A NCAC 27 G. 0104, available on the web at http://reports.oah.state.nc.us/ncac.asp. Please see the service definitions for which these staff qualifications apply at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdef3-27-06rev.pdf.

Clarification of Child Residential Rules and Service Definitions

Update #11 indicated the required four hours of treatment for each individual child could be provided by an AP or QP. While this is correct in the rules, it is clear in the Service Definition that the requirement can be met only by a QP providing the individual treatment. Therefore, it is expected the QP will provide the four hours of treatment described in the service definition.

Endorsement of Children's Residential Treatment Service Providers

We have received questions regarding endorsement of children's residential treatment provider and whether those endorsements should be conditional or full. The child residential treatment service definitions are not new; a large number of providers have been delivering the services for quite some time. Therefore, the standard endorsement policies outlined in Communication Bulletin # 44 should be followed. A provider who has experience in delivering the service should be reviewed for full endorsement. A provider who is just beginning to deliver the service should be reviewed for conditional endorsement for up to six months. Communication Bulletin # 44 is available on the DMH/DD/SAS website at
http://www.dhhs.state.nc.us/mhddsas/announce/commbulletins/combullerin044/commbulletin044endorsement-memo.pdf

Diagnosis Codes for Billing CS during the first 30 days

There has been some concern regarding how Community Support and Targeted Case Management (TCM) can be billed during the first 30 days prior to completion of the Diagnostic Assessment (DA) and Person Centered Plan since those services are subject to diagnosis edits. During the first 30 days of service the following ICD-9 codes may be used as appropriate:

V11.0 throughV11.9- Personal History of Mental Disorder
V40.0 through V40.9- Unspecified Mental or Behavioral Problem

Please note that after the DA is completed, V-codes can no longer be used for billing, and the diagnosis as determined through the DA must be reflected in the billing form as codes from the DSM-IV code series:

290.0 through 298.9
300 through 316.9

This information will be further clarified in an upcoming Medicaid Bulletin.

Addition to Clinical Policy 8A

5.5.2 Service Order for Development of the Person Centered Plan
The provision of CS for up to 448 units or TCM for up to 32 units during the first 30 days of service for the development of the Person Centered Plan does not require a service order. It is expected that the Person Centered Plan can be completed during the first thirty days of service or within the initial 448 units of Community Support or 32 units of TCM, prior to additional authorization. At the end of the 30 day period, if additional time is necessary to complete the PCP, there must be a review for the medical necessity of the extension with the appropriate agency, and a service order must be signed at that time.

TCM Overrides

We know that some providers have been caught by surprise by the $6,000 Medicaid annual limit on TCM. If a provider has received a denial for TCM (T1017HI) due to exceeding the $6000.00 annual limit that began starting with dates of service 9/1/05, and the provider wishes to have DMA reconsider the denial, they may send DMA a copy of the RA showing the denial, a copy of the case management plan and a copy of the progress notes for the year. The notes will be reviewed and if all services are determined to be medically necessary, DMA will direct EDS to override the limit and process the claims. The review will be completed within 5 days and providers will be notified of the results. Requests should be sent to: Behavioral Health Unit, DMA, 2501 Mail Service Center, and Raleigh, NC 27699-2501.

Since all TCM beyond the first 30 days for Medicaid is subject to prior authorization effective 9/1/06, the $6,000 annual edit is being removed for the future.

EPSDT OVERRIDES

Providers who have requested an EPSDT review from ValueOptions and have received an approval of that request **should not** send claims for that service directly with EDS. Instead, claims should be sent to the Behavioral Health Unit at DMA, 2501 Mail Service Center, Raleigh, NC 27699-2501 along with a copy of the approval letter. DMA will attach an override letter prior to transmitting the claim to EDS which will bypass the system limit and process the claim. Adherence to this process will significantly expedite payment for services/items approved under EPSDT.

ACTT

We recognize there have been some billing problems associated with Assertive Community Treatment Team (ACTT) services for consumers who have received other services earlier in the month. In cases where a provider begins delivering ACTT to a consumer who has received other services during the same month, prior to beginning ACTT, a system override will be needed for ACTT to pay for the first month. Claims for Medicaid eligible consumers should be sent, along with a copy of the authorization from ValueOptions for ACTT for the consumer to: the Behavioral Health Unit at DMA, 2501 Mail Service Center, Raleigh, NC 27699-2501. DMA will submit the claim to EDS with an override letter instructing them to process the claim overriding the other services restrictions and the 4 visit per month limit. LMEs should send claims for state-funded consumers in this situation to the Best Practice Team, 3005 Mail Service Center, Raleigh, NC 27699-3005. DMH/DD/SAS will submit the claim to EDS with an override letter instructing them to process the claim as outlined above.

ValueOptions Authorizations Letters

ValueOptions receives a provider file weekly from the Provider Enrollment Section at DMA via an EDS tape. This file lists the service address providers submitted to DMA for enrollment and is the address ValueOptions uses to mail letters. VO cannot change this address in their system and DMA cannot use a post office box as a physical address for enrollment. It is very important that providers ensure that the information regarding their physical address is current in the DMA Provider Enrollment files in order to ensure that VO authorization letters are delivered to the correct location.

Limitations on Providers on School Property

Due to the recent violent episodes in schools across the country, CMS has issued guidance to DMA regarding the provision of Medicaid services on school property by Medicaid direct enrolled providers. Despite the fact that the provider may be enrolled with Medicaid, schools may determine the providers with whom to contract, and, therefore, may control who physically comes on to school property and into the schools. However, once off school property, beneficiaries must have free choice of any willing and qualified provider of Medicaid services, and must be able to access all services in the community, beyond the school setting.

cc: Secretary Carmen Hooker Odom
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